Rules, Regulations and Administrative Information

This section of *Your King County Benefits* discusses your legal rights and presents some important administrative information.

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Insurance and Administrative Contracts

The benefit descriptions in this guide provide you with most of the information you'll need to know about your King County benefit package. However, they're not detailed descriptions. If you have questions about specific plan details or would like to review any of the insurance and administrative contracts, you may contact the plan's third-party administrator or Benefits and Retirement Operations. (See *Contact Information*.)

The county has made every attempt to ensure the accuracy of the information in this guide. However, if there is any discrepancy between the benefit descriptions in this guide and the insurance and administrative contracts, the contracts will always govern. In addition, no person has the authority to make any oral or written statements of any kind that would conflict with the contracts or would alter the contracts maintained in conjunction with the plans.

Your Patient Rights

When you're covered under the county health plans, you have certain rights and responsibilities the county wants you to know about.

Dignity and Respect Under Your Health Plans

You have the right to:

- be treated with consideration, dignity and respect. You also have the responsibility to respect the rights, property and environment of all providers and other patients; and
- see your own health records and have those records kept private and confidential unless required to settle a claim, for plan operations, for payment of claims, and as required by law.

You have these rights regardless of your gender, race, sexual orientation, marital status, culture or economic, educational or religious background.

Knowledge and Information Concerning Your Health Plans

You have the right and the responsibility to know about and understand your health care and your coverage, including:

- names and titles of all providers involved in your care;
- your health condition and status;
- services and procedures involved in your treatment;
- ongoing health care you need once you're discharged or leave the provider's office;

- how the plans work (see the appropriate plan sections of this guide); and
- any medication prescribed for you—what it is, what it's for, how to take it properly and possible side effects.

You also have the right to take an active part in decisions about your care. Once you participate in and agree to a treatment plan, you're responsible for following that plan or telling your provider otherwise.

Medical Plan Participant Accountability and Autonomy

As a partner in your own health care, you have the right to:

- refuse treatment as long as you accept the responsibility and consequences of that decision;
- complete an advance directive, such as a living will or durable power of attorney, for care;
- refuse to take part in any health care research projects;
- be advised on the full range of treatment options (whether or not covered under the plans) and their potential risks, benefits and costs; and
- make the final choice among treatment alternatives.

You're also responsible for:

- identifying yourself and covered family members to providers when you receive services by showing your plan ID card (if provided by your plan) or providing your complete Social Security number (or unique identifier number if issued by the plan);
- giving your current provider all previous and relevant health care records and submitting accurate, complete health information to all physicians or other providers involved in your care;
- being on time for appointments and letting your provider's office know as far in advance as you can if you need to cancel or reschedule;
- following instructions given by those providing your care;
- sending copies of claim statements or other documents if requested;
- letting your medical plan and primary care provider (if applicable) know within 24 hours, or as soon as reasonably possible, if you receive emergency care or out-of-area urgent care;
- telling the plan and your primary care provider (if applicable) about planned health care treatment, such as a surgery or an inpatient stay; and
- paying all required expenses not covered by the plan.

If you decide to give someone else the legal power to make decisions about your health care, that person also will have all of these rights and responsibilities.

Privacy Protection

To protect your privacy, the county and your plans limit the use of Social Security numbers unless otherwise legally required. Instead, the county and the plans use your PeopleSoft employee ID or a unique identifier number on ID cards, explanations of benefits or any other correspondence sent to you.

Continuous Improvement of Your Health Plans

You have the right to:

- contact Benefits and Retirement Operations with any questions or concerns and make suggestions for improving the plans (see *Contact Information*);
- ask your providers to explain or give you more information about any health advice or prescribed treatment; and
- appeal any health care or administrative decisions. (See "Claims Review and Appeals Procedures" on page 284.)

Your HIPAA Privacy Rights

This section of your guide describes how medical information about you may be used and disclosed by King County and how you can get access to this information. Please review all information carefully and, if you have any questions, contact Benefits and Retirement Operations. (See *Contact Information*.)

Our Obligations

We treat all protected health information (personally identifiable medical information) that you provide us to administer your health benefits as confidential. In addition, under the Health Insurance Portability and Accountability Act (HIPAA), we must:

- maintain the privacy of any protected health information you provide us when you enroll for benefit coverage, change coverage or ask for our assistance with a health benefit claim;
- inform you if there has been an inadvertent disclosure of your protected health information;

- obtain agreements with all vendors involved with the county's benefit plans to comply with HIPAA rules and regulations; and
- provide you with this information, which advises you of how we handle your protected health information and informs you of our legal obligations and your rights regarding the information.

For a complete summary of King County's obligations, refer to the "HIPAA Notice of Privacy Practices" on the Benefits and Retirement Web site. (See *Contact Information*.)

How We May Use and Disclose Protected Health Information

When you enroll for benefit coverage, change coverage or ask for our assistance with a health benefit claim, you provide us with information such as your name and possibly your Social Security number. Sometimes, when you ask for our assistance with a claim, you may also provide us with details about the health treatments you've received and payments for services you've made. This information becomes "protected health information" when used and disclosed in the course of managing our health care operations (administering your health benefits) and facilitating payment of health claims.

We may use and disclose this protected health information to:

- our employees authorized to assist in the administration of county benefit plans; and
- representatives of the plans or any third-party administrators with whom we have agreements to provide your benefit services.

In addition, we may use or disclose protected health information:

- when required by law—for example, in response to a court or administrative order, subpoena or discovery request; and
- when necessary to prevent a serious threat to your health and safety or the health and safety of the public.

For all the reasons explained above, we may use and disclose your personal health information without your written authorization. In all other cases, your written authorization is required.

Your Rights

For any protected health information provided to and maintained by us, you have the right to:

- inspect and copy it;
- request amendments to it if it's incorrect or incomplete (we may deny amendment requests for specific reasons—for example, we deny requests to amend information we didn't create);
- request to know to whom it's been disclosed (for disclosures made after April 14, 2003, when these HIPAA privacy practices became effective);
- request restrictions on what is disclosed and to whom (we try to honor restriction requests but are not required to do so); and
- request it be communicated to you in a certain way—for example, that we contact you only by mail or at work (we try to honor these requests but are not required to do so).

HOW TO CONTACT US

To exercise any of these rights, contact us in writing. Mail your request to:

Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle, WA 98104-1598

Or you can e-mail us at kc.benefits@metrokc.gov.

Changes to Our Privacy Practices

We reserve the right to change our privacy practices and to apply the new practices to protected health information we already have, as well as to any information we receive in the future. We'll notify you if we make changes and when the changes become effective.

Complaints

If you believe your privacy rights have been violated, you may file a complaint in writing with Benefits and Retirement Operations or the Office of Civil Rights within the U.S. Department of Health and Human Services. You won't be penalized for filing a complaint.

HOW TO CONTACT US

To file a complaint with Benefits and Retirement Operations, mail it to:

Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle, WA 98104-1598

Or you can e-mail us at kc.benefits@metrokc.gov.

Claims Review and Appeals Procedures

The procedures for filing claims for benefits are summarized in the respective plan overviews. If you're not satisfied with the outcome of your claim, you can ask to have the claim reviewed.

Almost all of the benefit plans described in this guide have a specific amount of time during which benefit claims can be evaluated and responded to. The period of time the plans have to evaluate and respond to a claim begins on the date the claim is first filed. In addition, there are specific timelines and information requirements that you must comply with when filing a claim, or the claim may be denied and the rights you might otherwise have may be forfeited.

As the plan administrator, King County has the authority to control and manage the operation and administration of the plans described in this guide. However, the county can assign specific operational or administrative responsibilities, such as processing claims, to a third-party administrator, which has final responsibility and authority for responding to claims appeals.

Aetna, for example, has responsibility for processing claims and handling claims appeals for the county's KingCare℠ plan. Group Health Cooperative, on the other hand, makes final decisions for benefit appeals for the county's Group Health plan.

Health Care Plans

In most cases, your health care provider will submit claims for health care services on your behalf. However, either you or your authorized representative may file claims for benefits under the county's health care plans (that is, medical, prescription drug, dental and vision). An "authorized representative" means a person you authorize, in writing, to act on your behalf. The plans also will recognize a court order giving a person the authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your authorized representative. All communications from the plans will be directed to your authorized representative unless your written designation provides otherwise.

KingCare℠

If a properly filed claim is denied in whole or in part, a KingCare℠ service representative will notify you and your provider with an explanation in writing. KingCare℠ may deny a claim on the basis of eligibility or for other reasons.

Claims Denied for Reasons Other Than Eligibility

If you or your representative disagrees with a claim denial, you may try to resolve any misunderstanding by calling Aetna, the appropriate claims administrator for KingCare℠, and providing more information. If you'd rather communicate in writing or the issue isn't resolved with a call, you may file a written appeal. (See *Contact Information*.)

You have 180 days after receiving a claim denial notice to file a written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

Aetna will review the written appeal and notify you or your representative of its decision within these time frames:

- within 72 hours for urgent appeals. These pertain to claims that have to be decided more quickly because using the normal time frames for decision-making could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed without the care or treatment that is the subject of the appeal;
- within 15 days for pre-service appeals (within 30 days if an extension is filed). These relate to claims for a benefit that must be approved before the patient receives medical care—for example, requests to precertify a hospital stay;
- within 20 days for post-service appeals (within 40 days if an extension is filed). These appeals involve the payment or reimbursement of costs for medical care that has already been provided; or
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim. These relate to claims where the plan has previously approved an ongoing course of treatment over a period of time or a specific number of treatments, and either the claims administrator later reduces or terminates coverage for those treatments before the end of that period or the covered person requests an extension of the course of treatment beyond the approved period of time or number of treatments.

Aetna will review your appeal, applying plan provisions and its discretion in interpreting plan provisions, and then will notify you of the decision within the time frames listed above. If the claim appeal is denied, you'll be notified in writing of reasons for the denial. Aetna has sole discretionary authority to determine benefit payment under KingCare℠, and its decisions are final and binding.

If the appeal is denied, legal remedies may be pursued, but you or your representative must first exhaust this claim appeal process. If legal action is taken, the suit must be filed within two years of the date of service on which the claim is based, or you forfeit your right to legal action.

You must file an appeal within the given time frame or you may forfeit your right to further consideration of your claim.

Claims Denied Due to Eligibility Issues

If you have eligibility questions or believe you've had a claim denied because KingCare℠ indicates you or a family member isn't covered under the plan, call Benefits and Retirement Operations. (See *Contact Information*.) A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or if your eligibility issue can't be resolved with a phone call, you or your representative (referred to as "you" in the rest of this section) may file a written appeal. You have 180 days after receiving a notice of your eligibility determination from the county or KingCare℠ to submit a written appeal. It must include:

- your name and address, as well as each covered family member's name and address, if applicable;
- hire letter or job announcement, or retirement determination of eligibility;
- your PeopleSoft employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member); and
- the reason for the appeal.

ELIGIBILITY APPEALS

Mail eligibility appeals to:

Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle, WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these time frames:

- within 3 business days for urgent appeals (call 206-684-1556 to file an urgent appeal);
- within 14 days for pre-service appeals (within 30 days if an extension is filed);
- within 20 days for post-service appeals (within 40 days if an extension is filed); and
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under KingCare℠, and its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements, and Benefits and Retirement Operations determines that you're entitled to benefits.

If you believe your eligibility appeal was denied because relevant information or documents weren't considered, Benefits and Retirement Operations offers the option of filing an eligibility appeal addendum within 60 days after you receive the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address for eligibility appeals, but to the attention of the Benefits and Retirement Operations manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. The manager's decisions are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be taken within two years of the date you or your family member is denied plan participation, or you forfeit your right to legal action.

Release of Medical Information

As a condition of receiving benefits under KingCare[SM], you and your family members authorize:

- any provider to disclose to Aetna any requested medical information;
- Aetna to examine your medical records at the offices of any provider;
- Aetna to release to or obtain from any person or organization any information necessary to administer your benefits; and
- Aetna to examine records that would verify eligibility.

Aetna will keep this information confidential whenever possible, but under certain necessary circumstances, it may be disclosed without specific authorization.

Prescription Coverage

Claims Denied for Reasons Other Than Eligibility

If you disagree with the decision on your claim, you (or your authorized representative) will have 180 days to file a written appeal after your receipt of the notice of adverse decision. The decision on your appeal will be based on all comments, documents, records and other information you submit, even if they weren't submitted or considered during the initial claim decision.

APPEALS OF AN ADVERSE DECISION

Mail appeals of an adverse decision to:

Express Scripts, Inc.
Attn: Pharmacy Appeals (KCW)
6625 West 78th Street
Mail Route: BL0390
Bloomington, MN 55439

You should include the reasons you believe the claim was improperly denied, and all additional facts and documents you consider relevant in support of your appeal. The following type of information is helpful when submitting your appeal so that it may be handled in a timely manner:

- employee's full name;
- patient's full name;
- your Express Scripts ID Number (located on the front of your prescription card);
- the date(s) services were provided;
- your mailing address;
- your daytime phone number(s);
- your e-mail address (if you would like to provide it);
- relevant information regarding the nature of your appeal; and
- a copy of your Explanation of Benefits, if applicable.

A new decision-maker will review your denied claim—the appeal will not be conducted by the individual who denied the initial claim. The new decision-maker will not give deference to the original decision on your claim. The reviewer will make an independent decision about the claim. If your claim was denied on the basis of medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in your claim.

For appeals of adverse decisions involving urgent care claims, the plan will accept either oral or written requests for appeals for an expedited review. All necessary information may be transmitted between Express Scripts and you or health plan providers by telephone, fax or other available expeditious methods.

Notice of Decision on Appeal

After your appeal is reviewed by Express Scripts, you'll receive a notice of decision on appeal within the time frames specified below. The time frames for providing a notice of decision on appeal generally begin when all necessary information has been received to perform the review. Notice of decision on appeal will be provided in writing. Urgent care decisions may be delivered by telephone, fax or other expeditious methods. The time frames for providing a notice of decision on appeal are as follows:

- urgent care appeals. As soon as possible considering the medical urgency, but no later than 72 hours after Express Scripts receives your appeal and all information necessary to perform review;
- pre-service appeals. Within a reasonable period of time appropriate to the medical circumstances, but no later than seven business days after Express Scripts receives your appeal and all information necessary to perform review; and
- post-service appeals. Within a reasonable period of time appropriate to the medical circumstances, but no later than seven business days after Express Scripts receives your appeal and all information necessary to perform review.

If the appeal is denied, legal remedies may be pursued, but you or your representative must first exhaust this claim appeal process. If legal action is taken, the suit must be filed within two years of the date of service on which the claim is based, or you forfeit your right to legal action.

Claims Denied Due to Eligibility Issues

If you have eligibility questions or believe you've had a claim denied because Express Scripts indicates that you or a family member isn't covered under the plan, call Benefits and Retirement Operations. (See *Contact Information*.) A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or if your eligibility issue can't be resolved with a phone call, you or your representative may file a written appeal with Benefits and Retirement Operations. You have 180 days after receiving a notice of your eligibility determination from the county or Express Scripts to submit a written appeal. It must include:

- your name and address, as well as each covered family member's name and address, if applicable;
- hire letter or job announcement, or retirement determination of eligibility;
- your PeopleSoft employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member); and
- the reason for the appeal.

ELIGIBILITY APPEALS

Mail eligibility appeals to:

Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle, WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these time frames:

- within 3 business days for urgent appeals (call 206-684-1556 to file an urgent appeal);
- within 14 days for pre-service appeals (within 30 days if an extension is filed);
- within 20 days for post-service appeals (within 40 days if an extension is filed); and
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under the prescription drug plan, and its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements, and Benefits and Retirement Operations determines that you're entitled to benefits.

If you believe your eligibility appeal was denied because relevant information or documents weren't considered, Benefits and Retirement Operations offers you the option of filing an eligibility appeal addendum within 60 days after you receive the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address as for eligibility appeals, but to the attention of the Benefits and Retirement Operations manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. The manager's decisions are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be taken within two years of the date you or your family member is denied plan participation, or you forfeit your right to legal action.

Group Health

If a properly filed claim is denied in whole or in part, a Group Health Cooperative service representative will notify you and your provider with an explanation in writing. Group Health may deny a claim on the basis of eligibility or medical necessity, or for other reasons.

Group Health has in place certain grievance processes that enable plan members to file a complaint and appeal a denial of benefits:

- the complaint process enables plan members to express dissatisfaction with customer service or the quality or availability of a health service; and
- the appeals process enables plan members to seek reconsideration of a denial of benefits.

Complaint Process

If you wish to file a complaint, you must follow these steps:

Step 1: Contact the provider, and explain your concerns and what you would like done to resolve the problem. Be specific and make your position clear.

Step 2: If you prefer not to talk with the provider or if you're not satisfied with the response, call the department head or the manager of the medical center or department where you're having a problem. That person will investigate your concerns. Most concerns can be resolved in this way.

Step 3: If you're not satisfied with the response, call the Group Health Customer Service Center. (See *Contact Information*.) Most concerns are handled by phone within a few days. In some cases, you'll be asked to write down your concerns and state what you think would be a fair resolution to the problem. A customer service representative or Member Quality of Care coordinator will investigate your concern by consulting with involved staff and their supervisors, and reviewing pertinent records, relevant plan policies and the Member Rights and Responsibilities statement. This process can take up to 30 days to resolve after receipt of your written statement.

Claims Denied for Reasons Other Than Eligibility

If you wish to appeal a decision denying benefits, you must follow these steps:

Step 1: Submit a request for an appeal either orally or in writing to the Member Appeals Department, specifying why you disagree with the decision. The appeal must be submitted within 180 days of the denial notice you received.

- If you live west of the Cascade Mountains, send your appeal to:

  Group Health's Member Appeals Department
  P.O. Box 34593
  Seattle, WA 98124-1593

  Or, you may call 206-901-7350 or 1-888-901-4636 toll-free.

- If you live east of the Cascade Mountains, send your appeal to:

  Group Health's Member Appeals Department
  P.O. Box 204
  Spokane, WA 99210-0204

  Or, you may call 509-241-7622 or 1-888-901-4636 toll-free.

An Appeals Coordinator will review initial appeal requests. Group Health will then notify you of its determination or need for an extension of time within 14 days of receiving your request for appeal. **Under no circumstances will the review time frame exceed 30 days without your written permission.**

If the appeal request is for an experimental or investigational exclusion or limitation, Group Health will make a determination and notify you in writing within 20 working days of receipt of a fully documented request. If additional time is required to make a determination, Group Health will notify you in writing that an extension in the review time frame is necessary. **Under no circumstances will the review time frame exceed 20 days without your written permission.**

An expedited appeals process is in place for cases that meet criteria or where your provider believes that the standard 30-day appeal review process will seriously jeopardize your life, health or ability to regain maximum function or subject you to severe pain that cannot be managed adequately without the requested care or treatment. You can request an expedited appeal in writing to the above address. Alternatively, you may call Group Health's Member Appeals Department:

- if you live in western Washington, call 206-901-7350 or 1-888-901-4636 toll-free; or
- if you live in eastern Washington, call 509-241-7622 or 1-888-901-4636 toll-free.

Your request for an expedited appeal will be processed and a decision issued no later than 72 hours after receipt.

Step 2: If you're not satisfied with the decision in Step 1 regarding a denial of benefits, or if Group Health fails to grant or reject your request within the applicable required time frame, you may request a second-level review by an external independent review organization as described in the first bullet below. You may also choose to pursue review by an appeals committee before requesting a review by an independent review organization as described in the second bullet below. **This isn't a required step in the appeals process**.

- **Request a review by an independent review organization.** An independent review organization isn't legally affiliated with or controlled by Group Health. Once a decision is made through an independent review organization, the decision is final and cannot be appealed through Group Health. You must request a review by an independent review organization within 180 days after the date of the Step 1 decision notice, or within 180 days after the date of a Group Health appeals committee decision notice.
- **Request an optional hearing by the Group Health appeals committee.** The appeals committee hearing is an informal process. The hearing will be conducted within 30 working days of your request, and you'll receive notification of the appeal committee's decision within 5 working days of the hearing. If you elect the appeals committee option, you maintain your right to appeal further to an independent review organization as described above. Review by the appeals committee isn't an option if the appeal request is for an experimental or investigational exclusion or limitation. You must request a review by the appeals committee within 30 days after the date of the Step 1 decision notice.

Requests can be mailed to the addresses listed under "Claims Denied for Reasons Other Than Eligibility" on page 292.

Claims Denied Due to Eligibility Issues

If you have eligibility questions or believe you've had a claim denied because Group Health indicates you or a family member isn't covered under the plan, call Benefits and Retirement Operations. (See *Contact Information*.) A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or if your eligibility issue can't be resolved with a phone call, you or your representative may file a written appeal. You have 180 days after receiving a notice of your eligibility determination from the county or Group Health to submit a written appeal. It must include:

- your name and address, as well as each covered family member's name and address, if applicable;
- your hire letter or job announcement, or retirement determination of eligibility;
- your PeopleSoft employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member); and
- the reason for the appeal.

ELIGIBILITY APPEALS

Mail eligibility appeals to:

Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle, WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these time frames:

- within 3 business days for urgent appeals (call 206-684-1556 to file an urgent appeal). These pertain to claims that have to be decided more quickly because using the normal time frames for decision-making could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed without the care or treatment that is the subject of the appeal;
- within 14 days for pre-service appeals (within 30 days if an extension is filed). These relate to claims for a benefit that must be approved before the patient receives medical care—for example, requests to precertify a hospital stay;
- within 20 days for post-service appeals (within 40 days if an extension is filed). These appeals involve the payment or reimbursement of costs for medical care that has already been provided; or
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim. These relate to claims where the plan has previously approved an ongoing course of treatment over a period of time or a specific number of treatments, and either the claims administrator later reduces or terminates coverage for those treatments before the end of that period or the covered person requests an extension of the course of treatment beyond the approved period of time or number of treatments.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

If you believe your eligibility appeal was denied because relevant information or documents weren't considered, Benefits and Retirement Operations offers you the option of filing an eligibility appeal addendum within 60 days after you receive the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address as for eligibility appeals, but to the attention of the Benefits and Retirement Operations manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. The manager's decisions are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be taken within two years of the date you or your family member is denied plan participation, or you forfeit your right to legal action.

Dental

If a properly filed claim is denied in whole or in part, WDS notifies you and your provider with an explanation in writing. When a claim is denied for any reason other than eligibility, follow the steps in “Claims Denied for Reasons Other Than Eligibility” on page 296. However, when a claim is denied for eligibility reasons, follow the steps in “Claims Denied Due to Eligibility Issues” on page 297.

Claims Denied for Reasons Other Than Eligibility

If you or your authorized representative disagrees with the claim denial, you may try to resolve any misunderstanding by calling or writing WDS and requesting an appeal of the decision. If you’re dissatisfied with the outcome of the review, you may request a second review by the WDS Appeals Committee. (See *Contact Information*.)

You have 180 days after receiving a claim denial notice to request an appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

WDS will review your written appeal and notify you or your representative of its decision within these time frames:

- within 72 hours for urgent appeals;
- within 15 days for pre-service appeals;
- within 30 days for post-service appeals; or
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

For second-level appeal reviews, your request for a review by the WDS Appeals Committee must be made within 90 days of the postmarked date of the letter notifying you of the informal review decision. Your request should include the information noted above, plus a copy of the informal review decision letter. You may also submit any other documentation or information you believe supports your case.

The WDS Appeals Committee includes only persons who weren't involved in either the original claim decision or the informal review. The WDS Appeal Committee will review your claim and make a determination within 30 days of receiving your request, or within 20 days for experimental/investigational procedure appeals, and send you a written notification of the review decision. Upon request, you'll be granted access to and copies of all relevant information used in making the review decision. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, WDS will consult with a dental professional advisor.

The decision of the WDS Appeals Committee is final. If you disagree with the outcome of your appeal and you have exhausted the appeals process provided by your plan, there may be other avenues available for further action. If so, these will be provided to you in the final decision letter. If legal action is taken, the suit must be filed within six years after the event on which the claim is based or you forfeit your right to legal action.

AUTHORIZED REPRESENTATIVE

You may authorize another person to represent you and to whom WDS can communicate regarding specific appeals. The authorization must be in writing and signed by you. If an appeal is submitted by another party without this authorization, a request will be made to obtain a completed Authorized Representative form. The appeal process won't commence until this form is received. If the form or some other document confirming the right of the individual to act on your behalf (that is, power of attorney) isn't returned, the appeal will be closed.

Claims Denied Due to Eligibility Issues

If you have eligibility questions or believe you've had a claim denied because WDS indicates that you or an eligible dependent isn't covered under the plan, call Benefits and Retirement Operations. (See *Contact Information.)* A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or if your eligibility issue can't be resolved with a phone call, you or your representative (referred to as "you" in the rest of this section) may file a written appeal. You have 180 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- your name and address, as well as each covered family member's name and address (if applicable);
- hire letter or job announcement, or retirement determination of eligibility;
- your PeopleSoft employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a dependent); and
- the reason for the appeal.

ELIGIBILITY APPEALS

Mail eligibility appeals to:

Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle, WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these time frames:

- within 3 business days for urgent appeals (call 206-684-1556 to file an urgent appeal);
- within 14 days for pre-service appeals (within 30 days if an extension is filed);
- within 20 days for post-service appeals (within 40 days if an extension is filed);
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under this plan, and its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements, and Benefits and Retirement Operations determines that you're entitled to the benefits.

If you believe your eligibility appeal was denied because relevant information or documents weren't considered, Benefits and Retirement Operations offers you the option of filing an eligibility appeal addendum within 60 days after you receive the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address as for eligibility appeals, but to the attention of the Benefits and Retirement Operations manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. The manager's decisions are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be taken within two years of the date you or your family member is denied plan participation, or you forfeit your right to legal action.

Vision

If a properly filed claim is denied in whole or in part, VSP notifies you and your provider with an explanation in writing. When a claim is denied for any reason other than eligibility, follow the steps in "Claims Denied for Reasons Other Than Eligibility" on page 299. However, when a claim is denied for eligibility reasons, follow the steps in "Claims Denied Due to Eligibility Issues" on page 300.

Claims Denied for Reasons Other Than Eligibility

If you or your representative disagrees with the claim denial, you may try to resolve any misunderstanding by calling VSP and providing more information. If you'd rather communicate in writing or if the issue isn't resolved with a call, you may file a written appeal with VSP. (See *Contact Information*.)

You have 180 days after receiving a claim denial notice to file a written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

VSP will review the written appeal and notify you or your representative of its decision within these time frames:

- within 72 hours for urgent appeals;
- within 30 days for pre-service appeals;
- within 30 days for post-service appeals (first and second-level appeals); or
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

Your appeal is reviewed by someone different from the original decision makers and without deference to the initial decision. The appeal reviewer applies plan provisions and his/her discretion in interpreting plan provisions, and then notifies you of the decision within the time frames listed above. If the claim appeal is denied, you're notified in writing of reasons for the denial.

If you disagree with the resolution of your claim, you have 60 days after receiving the denial to submit a second-level appeal with any further documentation to VSP.

VSP has sole discretionary authority to determine benefit payment under the plans; its decisions are final and binding.

If the appeal is denied, legal remedies may be pursued, but you or your representative must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event the claim is based on or you forfeit your right to legal action.

Claims Denied Due to Eligibility Issues

If you have eligibility questions or believe you've had a claim denied because VSP indicates that you or a dependent isn't covered under the plan, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or if your eligibility issue can't be resolved with a phone call, you or your representative (referred to as "you" in the rest of this section) may file a written appeal. You have 180 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- your name and address, as well as each covered family member's name and address (if applicable);
- hire letter or job announcement, or retirement determination of eligibility;
- your PeopleSoft employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a dependent); and
- the reason for the appeal.

ELIGIBILITY APPEALS

Mail eligibility appeals to:

Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle, WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these time frames:

- within 3 business days for urgent appeals (call 206-684-1556 to file an urgent appeal);
- within 14 days for pre-service appeals (within 30 days if an extension is filed);
- within 20 days for post-service appeals (within 40 days if an extension is filed); and
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under this plan, and its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements, and Benefits and Retirement Operations determines that you're entitled to the benefits.

If you believe your eligibility appeal was denied because relevant information or documents weren't considered, Benefits and Retirement Operations offers you the option of filing an eligibility appeal addendum within 60 days after you receive the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address as for eligibility appeals, but to the attention of the Benefits and Retirement Operations manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. The manager's decisions are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be taken within two years of the date you or your family member is denied plan participation, or you forfeit your right to legal action.

Flexible Spending Accounts

If a properly filed claim is denied, you (or your representative) may submit a written appeal to:

Fringe Benefits Management Company (FBMC)
P.O. Box 1878
Tallahassee, FL 32302-1878

Your written appeal must be filed within 180 days after you receive the initial notice of denial from FBMC. You must indicate the reason for your appeal and may include any relevant information or documents.

FBMC will give you a written decision within 60 days of receiving your appeal, indicating the specific plan provision behind the decision and advising you of your right to obtain free copies of related documentation.

If the appeal is denied, you may pursue legal remedies, but you or your representative must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event on which the claim is based.

Long-Term Disability Insurance

The county administers eligibility for participation in the long-term disability (LTD) insurance plan according to the terms of the insurance contract. CIGNA Group Insurance has the sole discretionary authority to apply the terms of the plan for the purpose of determining eligibility for claims payment and resolving claims appeals under the plan.

If your claim is denied, you'll be notified in writing of the reasons for the denial, your right to appeal and your right to obtain copies of all documents related to your claim that were reviewed by CIGNA in making the determination.

Claims Denied for Any Reason

If you disagree with the claim denial, you or your representative (referred to as "you" in the rest of this section) may attempt to resolve any misunderstanding by calling CIGNA and providing additional details. If you prefer to communicate in writing or are unable to resolve the issue with a phone call, you may file a written appeal. You have 180 days after receiving the claim denial notice to file a written appeal. Be sure to include the reasons for your appeal and any information or documentation helpful in reviewing your claim.

CIGNA will review your written appeal and notify you of its decision within 45 days after receiving your appeal. If CIGNA requires additional time, you'll be notified in writing that an additional period of up to 45 days is necessary.

CIGNA will give you a written decision and explain the specific plan provisions behind the denial (if applicable).

CIGNA has sole discretionary authority to determine payment of LTD benefits, and its decision is final and binding. In reviewing your claim, CIGNA applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements, and CIGNA determines you're entitled to the benefits.

If your appeal is denied, you may pursue legal remedies, but you must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within three years after the time written proof of loss is required to be furnished or you forfeit your right to legal action. If you don't file a claim or appeal within the specified period, you forfeit the right to further appeal.

IF YOU HAVE QUESTIONS ABOUT ELIGIBILITY

If you have questions about your eligibility to participate in this plan, contact Benefits and Retirement Operations at 206-684-1556 or kc.benefits@metrokc.gov. You may also write to:

Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle, WA 98104-1598

When writing, be sure to include your name and address, your PeopleSoft employee ID (as it appears on your pay stub) and a phone number where you can be reached during weekday business hours.

Life Insurance Plan

The county administers eligibility for participation in the life insurance plan according to the terms of the insurance contract. Aetna Life Insurance has the sole discretionary authority to apply the terms of the plan for the purpose of determining eligibility for claims payment and resolving claims appeals under the plan.

When a claim is denied for any reason, follow the steps in “Claims Denied for Any Reason” on page 303.

Claims Denied for Any Reason

If you or your beneficiary disagrees with a claim denial, you, your beneficiary or representative (referred to as “you” in the rest of this section) may file a written appeal. You have 60 days after receiving a claim denial notice to file the written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

Aetna will review the written appeal and notify you of its decision within 60 days after receiving the appeal. If Aetna requires additional time, you will be notified in writing that an additional period of up to 60 days is necessary.

Aetna will give you a written decision and explain the specific plan provisions behind the denial (if applicable).

Aetna has sole discretionary authority to determine benefit payment under the life insurance plan, and its decision is final and binding. In reviewing your claim, Aetna applies the plan terms. Benefits are paid only if you meet the eligibility and participation requirements, and Aetna determines that you’re entitled to the benefits.

If the appeal is denied, you may pursue legal remedies, but you must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event on which the claim is based. If you don’t file a claim or appeal within the specified period, you forfeit the right to further appeal.

IF YOU HAVE QUESTIONS ABOUT ELIGIBILITY

If you have questions about your eligibility to participate in this plan, contact Benefits and Retirement Operations at 206-684-1556 or kc.benefits@metrokc.gov. You may also write to:

Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle, WA 98104-1598

When writing, be sure to include your name and address, your PeopleSoft employee ID (as it appears on your pay stub) and a phone number where you can be reached during weekday business hours.

Accidental Death and Dismemberment Insurance Plan

The county administers eligibility for participation in the accidental death and dismemberment (AD&D) insurance plan according to the terms of the insurance contract. CIGNA Group Insurance has the sole discretionary authority to apply the terms of the plan for the purpose of determining eligibility for claims payment and resolving claims appeals under the plan.

When a claim is denied for any reason, follow the steps in “Claims Denied for Any Reason” on page 304.

Claims Denied for Any Reason

If you or your beneficiary disagrees with a claim denial, you, your beneficiary or representative (referred to as “you” in the rest of this section) may try to resolve any misunderstanding by calling CIGNA and providing more information. If you’d rather communicate in writing or if the issue isn’t resolved with a call, you may file a written appeal. You have 60 days after receiving a claim denial notice to file the written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

CIGNA will review your written appeal and notify you of its decision within 60 days after receiving the appeal. If CIGNA requires additional time, you’ll be notified in writing that an additional period of up to 60 days is necessary.

CIGNA will give you a written decision and explain the specific plan provisions behind the denial (if applicable).

CIGNA has sole discretionary authority to determine benefit payment under the AD&D insurance plan, and its decision is final and binding. In reviewing your claim, CIGNA applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements, and CIGNA determines you’re entitled to the benefits.

If the appeal is denied, you may pursue legal remedies, but you must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within three years after the time written proof of loss is required to be furnished. If you don't file a claim or appeal within the specified period, you forfeit the right to further appeal.

IF YOU HAVE QUESTIONS ABOUT ELIGIBILITY

If you have questions about your eligibility to participate in this plan, contact Benefits and Retirement Operations at 206-684-1556 or kc.benefits@metrokc.gov. You may also write to:

Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle, WA 98104-1598

When writing, be sure to include your name and address, your PeopleSoft employee ID (as it appears on your pay stub) and a phone number where you can be reached during weekday business hours.

Assignment of Benefits

Plan benefits are available only to you and your covered dependents. In general, they cannot be assigned or given away to another person and are not subject to attachment or garnishment. However, there are exceptions. Contact Benefits and Retirement Operations for details. (See *Contact Information*.)

Determining Payment of Benefits

In paying for services, the plans may, at their option, pay you, the provider or another third-party administrator. The plans also will make payments on behalf of an enrolled child to his/her parent who may not be enrolled in the plan or to a state Medicaid agency when required to do so by federal or state law. In these cases, the plans also have the right to make joint payments.

All payments are subject to applicable federal and state laws and regulations. When the plans make payments according to the information in this section, they're released from liability to anyone who disagrees with their decision to pay certain individuals or agencies.

Third-Party Claims

If you receive health benefits for any condition or injury for which a third party is liable, the plans may have the right to recover the money they paid for benefits. Third-party claims are handled differently by the different health plans. (For details, see the separate sections on third-party claims under KingCare[SM], Group Health and WDS in the *Health Care* section.)

Correcting Mistakes in Payments

Each plan has the right to recover amounts it paid that exceed the amount for which it is liable. These amounts may be recovered from one or more of the following (to be determined by the plan):

- persons to or for whom the payments were made;
- other insurers;
- service plans; and
- organizations or other plans.

These amounts may be deducted from your future benefits or a family member's benefits, even if the original payment wasn't made on the family member's behalf.

The plan's right of recovery includes benefits paid in error due to, but not limited to, any false or misleading statements made by you or your family members.

Change or Termination of the Plans

The county fully intends to continue the plans indefinitely but reserves the absolute right to amend or terminate them, in whole or in part, for any reason at any time, according to the amendment and termination procedures described in the legal documents. If the county amends or terminates the plans, bona fide claims incurred before the amendment or termination will be paid.

Employment Rights Not Implied

The benefit information in this guide does not create a contract of employment between the county and any employee.